CPCA
California Primary Care Association

Health Care Access for All

Testimony
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The California Primary Care Association (CPCA) is the statewide leader and recognized voice of California's community clinics and health centers and their patients. CPCA represents over 600 non-profit clinics that provide comprehensive, quality health care services for low-income, uninsured, and underserved Californians who might otherwise not have access to health care.

First, on behalf of our membership, we would like to join the many voices in thanking the more than 250 state employees, California Performance Review (CPR) staff and the Commissioners for their thoughtful and thought provoking recommendations outlined in the CPR.

The CPR was released at a time when we in the health care community were anticipating another major health care proposal, the Medi-Cal Redesign. The postponed release of the Redesign allows the health care community the opportunity to focus on the CPR recommendations. We also strongly urge the Administration in its development of the Medi-Cal Redesign to focus its efforts in a similar manner as the CPR -- on administrative simplification, the elimination of bureaucratic barriers and the enhancement of customer-oriented services. As the CPR highlights, hundreds of millions of dollars in health care funding can be saved in streamlining efforts that support Medi-Cal beneficiaries and beneficiaries of other health care programs. The Administration must exhaust these efforts at cost savings prior to proposing any measures that may adversely impact beneficiaries and the providers that care for them.

CPR Recommendation on Consolidation of Licensure and Certification Processes
We strongly share the CPR's commitment to administrative efficiencies especially when safety-net providers and those we serve can be positively impacted. Consolidation of licensing and certification should improve state services by reducing unnecessary administrative duplication

and improving coordination. One of the potential efficiencies noted by the CPR includes the development of a common professional skill set for staff. While the development of a standardized skill set should improve the licensing and credentialing of providers, it is imperative that any consolidation proposal also ensure that surveyors are adequately trained regarding the specific statutory and regulatory provisions governing specific facilities. Currently, primary care clinics confront L&C surveyors that apply inapplicable requirements, apply underground regulations, and fail to enforce existing statutes.

Further streamlining of the licensure and certification process for the many government-sponsored health care programs should be explored. For example, community clinics and health centers must complete an arduous licensing process before they can provide health care. The end result of the licensing processes is the issuance of a Medi-Cal provider number. After being issued a Medi-Cal provider number, a clinic must fill out separate applications for each of the other government-run health programs for low-income populations. These additional programs conduct an enrollment process that often mirrors that of the Medi-Cal program, leading to unnecessary and costly administrative duplication.

Permitting primary care clinics (and other similarly situated providers) to enroll into Medi-Cal and other public health programs during the extensive Medi-Cal licensure and certification process would reduce unnecessary administrative costs for the clinics and the state.

CPR Recommendation on *e*-TAR Statewide Implementation

According to a 2003 Medi-Cal Policy Institute report on the TAR process, Medi-Cal patients have been put at risk by preauthorization delays, which force providers to delay necessary care.[1] If providers serve these patients, which most do, then they are put in financial risk because they cannot be reimbursed until authorization is secured retroactively. Statewide implementation of the *e*-TAR system should reduce processing time and we are extremely supportive of this effort. The Medi-Cal Policy Institute report discusses how most organizations that process authorization requests for services use the National Committee on Quality Assurance (NCQA) standard of 2 days turnaround. In 2003, processing time for Medi-Cal TARs averaged between 9 and 12 working days.[2] In order to ensure Medi-Cal patients receive timely access to necessary care and providers are also reimbursed in a timely fashion, the NCQA standard turnaround times should be adopted for *e*-TAR processing.

The Medi-Cal Policy Institute report highlights various recommendations for improving provider experience with the TAR system, which should be explored in the statewide implementation of the *e*-TAR system. For example, the report recommends the development of clear guidelines or criteria for adjudication practices, standardizing documentation of medical necessity, and providing explanations of denials. The report also recommends that the number of services subject to TARs be reduced after a cost-benefit analysis is performed. The report also includes recommendations regarding the authorization of pharmaceuticals. The report recommends revisiting the six prescription limit and either increasing the limit or eliminating it for some drugs. For example, maintenance drugs for chronic conditions and any other drugs that are routinely approved should not be subject to the limit.

CPR Recommendation on Other Health Coverage and Medi-Cal

The CPR also discusses the role of Medi-Cal as the payer of last resort, which can only be billed for services that other health coverage (OHC) or Medicare does not pay for. The CPR proposes

[1] Medi-Cal Policy Institute, Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care, July 2003.
[2] Ibid.

to develop a process for recording OHC electronically, rather than relying on the current manual operation. The CPR also proposes to initiate a process for disenrolling Medi-Cal managed care beneficiaries who have OHC.

Medi-Cal beneficiaries with OHC currently face difficulties in accessing all their entitled benefits and navigating between the OHC and Medi-Cal program. This proposal could exacerbate those problems and decrease access if the disenrollment of Medi-Cal managed care beneficiaries with OHC is not done in a way that ensures they continue to have access to their full entitlement of benefits. This proposal could be improved if DHS developed a system to ensure that the process for Medi-Cal beneficiaries with OHC is seamless. Individuals eligible for Medi-Cal must be promptly repaid for any out-of-pocket costs, and must have access to a comprehensive benefit package as required by Medi-Cal.

As currently drafted, the CPR proposal's narrow scope on improving the identification of Medi-Cal beneficiaries with OHC does not addressing other significant problems faced by these dually covered individuals and those that serve them. For example, a streamlined process to ensure timely payments of claims needs to be developed. Providers currently face difficulty in collecting reimbursement or long delays in securing reimbursement for Medi-Cal beneficiaries with OHC due to administrative processes between DHS and the third party payor. DHS should institute a policy for ensuring providers are paid for claims in a specified amount of time.

CPR Recommendation on Realignment

The CPR also recommends that a statewide Medically Indigent Adult (MIA) program be created with standard eligibility criteria. Under the proposal, the state would seek to contract for MIA services as it does for Medi-Cal and Healthy Families services, using the leverage of a large patient population to maximize cost effectiveness. Community clinics and health centers are concerned that realignment of MIA programs will result in reduced services in counties that currently provide comprehensive care to indigent adult. Many county MIA programs some of the most vulnerable populations including some immigrant groups. This population would be in jeopardy of losing coverage in a realignment to the state. The CPR should look at existing relationships between county MIA programs and community based organizations. Realigning MIA could have a damaging effect on the existing local health care delivery system. If adopted, the state needs to ensure that realignment does not result in destabilization of this system.

CPR Recommendation on SMART Cards

The use of smart card technology as outlined in the CPR raises several serious concerns that will decrease access to services. Fingerprints are not reliable for either children or elderly persons so a fingerprint from the parent or guardian would need to be used. For children in immigrant families, this requirement would generate fear, as immigrant parents may need to provide their fingerprints for their children to receive health care services. Based on previous experiences, fear and mistrust in the immigrant community can cause patients to not access needed health care and potentially impacting the financial viability of those that care for these populations.

Putting the provider in the role of collecting fingerprints at the initial visit is an inappropriate use of the health care delivery system that already lacks adequate resources for needed health care services. This additional task would require new equipment, consume valuable staff time to explain the rationale for collecting fingerprints, and create potential mistrust in the physician-patient relationship. Community clinics and health centers will oppose any efforts to force our staff to conduct this activity.

Although our membership does not support the adoption of SMART cards, we are excited to work with the Administration and its Departments on the implementation of many of the other recommendations in the area of health services.